CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				ON	1B NO. 0938-0391	
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING			COMPLETED		
		155570				07/28/2	2011	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R						
DIEVEV	NT VIEW LODGE		7476 W LANE RD MC CORDSVILLE, IN46055					
PLEASA	NT VIEW LODGE			INIC CC	RDSVILLE, IN46055			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0000								
	This visit was fo	or a Recertification and	FO	0000	August 15, 2011Kim Rhoad			
	State Licensure	Survey			DirectorLong Term CareDe			
					Rhoades,Please accept ou			
	Curvoy datas: I	uly 25, 26, 27, and 28,			of Correction as our credita			
	1 *	ury 23, 26, 27, and 28,			allegation of compliance. I			
	2011				have any questions please free to call me at	ieei		
					317-335-2159.Sincerely,Co	illeen		
	Facility number	: 000477			McCreary-Warnick Adminis			
	Provider numbe	er: 155570			Pleasant View Lodge			
	AIM number: 1	00290860			1			
		302,000						
	Cumulari taamai							
	Survey team:	N. T.C.						
	Barbara Gray R							
	Sharon Lasher F							
	(July 25 and 26,	, 2011)						
	Leslie Parrett							
	(July 26, 27, and	d 28. 2011)						
	Cheryl Fielden	•						
	Cheryr rielden							
	C	-						
	Census bed type	÷.						
	SNF/NF: 37							
	Total: 37							
	Census payor ty	rpe:						
	Medicare: 1	_						
	Medicaid: 32							
	Other: 4							
	Total: 37							
	Sample: 10							
	These deficience	ies reflect state findings						
	cited in accordance with 410 IAC 16.2							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BQ1Q11

Facility ID:

000477

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 07/28/2011		
		155570	B. WIN	G		07/28/2	011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7476 W LANE RD MC CORDSVILLE, IN46055					
(X4) ID	SUMMARVS	TATEMENT OF DEFICIENCIES	1	ID I			(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Æ	DATE	
F0328 SS=D	proper treatment a special services: Injections; Parenteral and ent Colostomy, ureterd Tracheostomy care; Tracheostomy care; Foot care; and Prostheses. Based on observative record review, the their policy and prostheses were not residual were not observations of grample of 10. Findings include During observative p.m. LPN #1 protube feeding to renot wear gloves, gastric tube (injet the gastric gurglet (use a syringe an g-tube and pull becontents).	RN insure that residents receive and care for the following steral fluids; ostomy, or ileostomy care; e; g; ation, interview and re facility failed to follow procedure for g-tube (a) tube) feeding in that tworn, placement and the checked for one of two restrict tube feedings in a (Resident #4)	F0	328	F328Resident #4 was admitt on 10/21/2010. The resident not had any infections related his g-tube or a diagnosis of aspiration pneumonia since admission.1. Corrective action: We reviewed the police and procedure on g-tube administration one on one withis L.P.N. We reviewed the of gloves and checking placement prior to administrate feedings through the g-tube. Identification of any other resident: No other residents waffected due to no other resident ag-tube.3. Measures thave a g-tube.3. Measures thave a g-tube.3. Measures thave a g-tube.4 licentures will be in-serviced on checking placement of a g-tuprior to administration of a feeding and wearing gloves wat administering a feeding through the g-tube. Licensed nurses do a return demonstration by 8/16/2011.4. Continued monitoring: The Director of	t has t has d to Ey ith use ating 2. eyere dents to ased abe while ugh will	08/16/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155570		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 07/28/2011			
	PROVIDER OR SUPPLIER		B. WING O772572011 STREET ADDRESS, CITY, STATE, ZIP CODE 7476 W LANE RD MC CORDSVILLE, IN46055				
PLEASA (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCE REGULATORY OR 7/25/11 at 1:30 p following. Resident #4's phy 12/3/10 indicated g-tube twice dailing tube with 120 d water before and Interview with L p.m., indicated sl placement of the the g-tube is ched did that this more she does not weat looks messy. A document prove Administrator on titled "Gastric Tu (Bolus)" dated 10 Administrator as policy for gastric the following: Steps in the proceeding air into stethoscope to the bubbling sound. heard, notify your	ysician order dated I "Boost: 1 can bolus per y and before meals, flush ace (cubic centimeters) after Boost feeding." PN #1 on 7/25/11 at 2:15 me did not listen for g-tube but once a shift, acked for residual and she ming. She also indicated ar gloves unless the g-tube yided by the 17/26/11 at 9:40 a.m., abe Feeding via Syringe 10/10, and indicated by the the facility's current tube feeding, indicated edure, wear clean gloves, of tube by forcefully tube while listening with e abdomen for a loud (Note: if no sound is	I		ill be or the ering ing or our if the eved week itor Date		
	note amount, if a	ny.					

I '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
155570		A. BUILDING B. WING 00 07/28/2011						
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7476 W LANE RD MC CORDSVILLE, IN46055					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE	
F0372 SS=F	refuse properly. Based on observation facility failed to place facility grounds, containing trash to parking lot for 4 potential to affect wearing wanderg 10. Findings include: On 7/26/2011 trailings burn pile act The trash observe contained 2 large box, metal strips attached, assorted metal fencing, a pieces of burnt between the second pieces of burnt between the second property of the	sh was observed in a ljacent to the parking lot. ed in the large burn pile pizza boxes, a cookie with bolts and washers I large cardboard boxes, large tree stump, and	F03	372	F372The burn pile was locate adjacent to the lower parking No residents go into this area all. The residents stay within fenced ground unless supervone on one by a staff member family member. Visitors must have put some of the debris in pile due to the facility has a true dumpster located on the property. These nine confuse residents have a wanderguant bracelet on each of them. The prevents them from going out unsupervised. 1. Corrective Action: The burn pile was clear up completely on 8/12/2011. facility will no longer have a begile. 2. Identification of any or residents: No other residents affected. 3. Measures to pre reoccurrence: The facility has eliminated the burn pile. A method to all staff has been developed in-service was conducted on 8/11/2011 concerning this plate.	lot. a at the rised er or t in the rash d d d his tside aned The burn ther were vent	08/12/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BQ1Q11 Facility ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155570	B. WIN			07/28/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1			
DIEAGAI	NT VIEW LODGE		7476 W LANE RD MC CORDSVILLE, IN46055				
FLEASAI	NI VIEW LODGE			I WIC CO	RDSVILLE, IN40055		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		<u> </u>	TAG	DEFICIENCY)	DATE	
	large burn pile adjacent to the parking lot.				correction for the maintenance	ce	
	The trash observ	ed in the large burn pile			department.4. Continued		
	contained metal	strips with bolts and			monitoring:Maintenance sup- or or their designee will moni		
		l, assorted large cardboard			the area where the burn pile		
		cing, a large tree stump,			four times a week for 30 days	•	
	and pieces of but	-			100% is achieved they will		
	and pieces of our	int ooard.			monitor two times a week for	•	
	07/20/2011	-1 1 1. ·			days. If 100% is achieved th		
		sh was observed in a			will monitor for one time a we	l l	
		djacent to the parking lot.			for 30 days. If 100% is achie then they will monitor bi-wee		
	The trash observe	ed in the large burn pile			for indefinitely.5. Date of	KIY	
	contained 1 pizza	a box, metal strips, water			completion:8/12/2011		
	bottles, assorted	large cardboard boxes, a					
	large mail shelf,	wood work trim, plastic					
	_	rnt wood, and other					
	miscellaneous ite						
	imbeenaneous ite						
	 On 7/27/11 at 2∵1	15 P.M., the Assistant					
		ing provided a list of 9					
		ore wanderguards.					
	residents who we	ore wanderguards.					
	The one-in-	tol tour vivos oon directs d					
		tal tour was conducted					
		strator and Housekeeping					
	•	28/2011 at 11:55 A.M.					
		ity grounds was observed					
	on 7/28/2011 at 1	12:50 P.M. During an					
	interview at that	time the Administrator					
	indicated she had	d observed the pizza box					
	and a pop can in the pile. The Administrator indicated the burn pile was originally to burn boxes. The Administrator indicated she had raked the						
		fter a previous discussion					
	concerning the b	urn pile.					

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
		155570	B. WING			07/28/2011		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER							
PI FASAI	NT VIEW LODGE		7476 W LANE RD MC CORDSVILLE, IN46055					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL						COMPLETION	
TAG			-	TAG DEFICIENCY)			DATE	
	3.1-21(i)(5)							
F0441	The facility must e	stablish and maintain an	1					
SS=D	_	Program designed to provide						
00 2	a safe, sanitary an	d comfortable environment						
	and to help prever	nt the development and						
	transmission of dis	sease and infection.						
	(a) Infection Contro							
	_	stablish an Infection Control						
	Program under wh							
		ontrols, and prevents						
	infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual							
	resident; and	e applied to all illulvidual						
		cord of incidents and						
	· ·	related to infections.						
	(b) Preventing Spr	read of Infection						
		ction Control Program						
	determines that a	resident needs isolation to						
	prevent the spread	d of infection, the facility						
	must isolate the re							
	(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or							
	,	contact will transmit the						
	disease.	at require staff to week their						
		st require staff to wash their direct resident contact for						
		ng is indicated by accepted						
	professional practi							
	r. S. SSSISIIAI PIAGU	··						
	(c) Linens							
		andle, store, process and						
		as to prevent the spread of						
	infection.	•						
	Based on observa	ation, interview and	F0	441	F441Resident #4 was admitt	ed	08/16/2011	
		e facility failed to follow			on 10/21/2010. The resident	has		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155570	B. WIN	G		07/28/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SUFFLIER			7476 W	LANE RD		
	NT VIEW LODGE			MC CO	RDSVILLE, IN46055		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		d 4.c	DATE
		procedures related to			not had any infections relate his g-tube or a diagnosis of	u to	
	failing to wear gl				aspiration pneumonia since		
	_	g-tube (gastric (stomach)			admission.1. Corrective		
		one of two observations			Action:We reviewed the police	-	
	of gastric tube fe	edings in a sample of 10.			and procedure on the use of		
	(Resident #4)				gloves when administrating a	3	
					g-tube feeding with this L.P.N.This L.P.N. performed	a	
	Findings include	<u>.</u>			return demonstration of the u		
					gloves while administrating a		
	During observation on 7/25/11 at 1:15				g-tube feeding on 8/13/2011	.2.	
		ovided a bolus gastric			Identification of any other		
	tube feeding to resident #4. LPN #1 did not wear gloves.				residents:No other residents		
					affected due to no other resine have a g-tube.3. Measures		
	not wear groves.				prevent reoccurrence:All lice		
	D : 0.1	1 CD :1 4 //4			nurses will be in-serviced by		
		cord of Resident #4 on			8/16/2011 on the proper use		
	7/25/11 at 1:30 p	.m. indicated the			gloves while administrating a		
	following.				g-tube feeding and provide r demonstration to the Directo		
					Nursing or her designee.4.	1 01	
		ysician order dated			Continued monitoring:The		
	12/3/10 indicated	l "Boost: 1 can bolus per			Director of Nursing or her		
	g-tube twice dail	y and before meals, flush			designee will be responsible		
	g-tube with 120 o	cc (cubic centimeters)			monitoring for the use of glo	/es	
	water before and	after Boost feeding."			while administering a g-tube feeding. The Director of Nurs	sina	
					or her designee will monitor	~	
	Interview with L	PN #1 on 7/25/11 at 2:15			use of gloves four times a w		
	p.m., indicated sl	he does not wear gloves			for thirty days. If 100% is		
	unless the g-tube	•			achieved they will monitor tw		
		<i>J</i> -			times a week for thirty days. 100% is achieved they will	IŤ	
	A document prov	vided by the			monitor one time a week for	thirty	
	_	7/26/11 at 9:40 a.m.,			days. If 100% is achieved the		
		ibe Feeding via Syringe			they will monitor bi-weekly fo		
		0 , 0			indefinitely.5. Corrective		
	l ` ′	0/10, and indicated by the			date:8/16/2011		
		the facility's current					
	policy for gastric	tube feeding, contained					

000477

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155570		(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 07/28	(X3) DATE SURVEY COMPLETED 07/28/2011					
	NAME OF PROVIDER OR SUPPLIER PLEASANT VIEW LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7476 W LANE RD MC CORDSVILLE, IN46055						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE				
	a procedure to w	rear clean gloves.								
	3.1-18(j)									